Insurance Election Form

Benefits and Employee Services
Shelbie King Hall 102
256.824.6640

The following is a request to change insurance elections (outside of the annual open enrollment) due to a change in family status. This request is made respective to my current elections and new elections are not allowed. Please return within 31 days of your change in family status to: Employee Benefits, SKH 102

CHANGE REASON:

- ❑ Marriage
- ❑ Divorce
- ❑ Death
- ❑ Change of Spouse Job
- ❑ Birth or Adoption of child
- ❑ Dependent Cease to be Eligible: ❑ Age of Dependent over 26 ❑ Dependent has other coverage

NATURE OF CHANGE:

- ❑ Enroll / New Application ❑ Cancel Coverage
- ❑ Remove Spouse only
- ❑ Change from Single to Family Coverage (Add eligible dependents)
- ❑ Change from Family to Single Coverage (Remove Dependents)
- ❑ Add Dependent Child

BIOGRAPHICAL INFORMATION

Prefix _____ First Name _____ M.I. _____ Last Name _____

Street Address _____ City, State, Zip Code _____

Phone _____ Email Address _____

Social Security Number _____ Banner ID _____

Date of Birth _____ Gender Male ❑ Female ❑ Marital Status Single❑ Married❑ Divorced❑ Widowed❑

Date Event Occurred: _____ (Example: Date of Marriage, divorce, birthdate of child, etc) Effective Date of Change: _____

ABOUT YOUR DEPENDENTS (Documentation is required to enroll an eligible dependent to your insurance selection (s))

Dependent Name (First, Middle Initial, Last)	Birthdate MM/DD/YY	Social Security Number	Gender M/F	Medical Y/N	Dental Y/N	Vision Y/N	Relationship to you

MEDICAL CARE – Blue Cross Blue Shield of Alabama

If you choose to enroll in the following benefit options, your contributions will be subtracted from your paycheck on a pre-tax basis. This means that you cannot change your benefit elections during the year unless you have a qualifying event (marriage, divorce, birth, etc). Premiums based on Bi-Weekly Payroll Period and are subject to change.

COVERAGE TYPE	EMPLOYEE PAYS	
❑ Waive Coverage		
❑ Single	$ 30.00	
❑Family	$ 85.00	Salary $20,000 or less
	$140.00	Salary over $20,000 – $40,000
	$180.00	Salary over $40,000

Please complete if you selected medical coverage:

Do you, your spouse or dependents have other medical coverage? ❑ Yes ❑ No
Do you, your spouse or dependents have Medicare coverage? ❑ Yes ❑ No
Do you, your spouse or dependents have COBRA coverage? ❑ Yes ❑ No
(If you answer yes, please complete the attached form)

DENTAL CARE-MetLife

COVERAGE	SINGLE PREMIUM	FAMILY PREMIUM
❑ Waive Coverage		
❑Basic	❑ $11.45	❑ $26.35
❑Comprehensive	❑ $19.55	☐ $45.04

VISION CARE-VSP

COVERAGE	COVERAGE PREMIUM
❑ Waive Coverage	
❑ Single	$ 3.92
❑ Family	$11.28

AUTHORIZATION

I have read and understand the benefit options available to me under The University of Alabama in Huntsville's benefits program. I understand that the benefits listed on this confirmation statement will remain in effect throughout the end of the benefit plan year unless I have a change in family and/or work status as defined by law. I acknowledge the decisions I have made for myself, and I authorize the company to withhold from my pay any of my pre-tax contributions as indicated above. I also confirm that the dependent information listed is correct to the best of my knowledge. I acknowledge and have read the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Women's Health and Cancer Rights Act Notice on the reverse of this form. The University of Alabama in Huntsville reserves the right to change or terminate benefit plans at any time. Please consult your summary plan descriptions for a full of benefits.

Signature _____ Date _____

HR Use Only
Entered _____ DEDN ___ BCOV ___ BCBS _____

IMPORTANT DISCLOSURE NOTICE

Notice of Group Health Plan Special Enrollment Rights

If you are declining enrollment for health plan benefits for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact UAH Employee Benefits at 824-6640.

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 requires group health plans to provide benefits for mastectomy-related services. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Other Group Health Insurance Coverage

❑ Individual ❑ Family

❑ Medical ❑ COBRA ❑ Medicare
Part A ___ Part B ___ Part D ____ Effective Date _____

Contract Holder's Full Name _____

Employer Name _____

Employer City _____

Group Number _____ Policy, ID, Contract or Certificate No. _____

Effective Date: _____ Insurance Company Name

Street Address _____

Suite /Building _____

City _____ State _____ Zip Code _____